

MARYLAND

3025

STATE DEPARTMENT OF HEALTH

03009

CERTIFICATE OF DEATH

Reg. Dist. No. 351

| | | | |
|---|---------------------|--|---|
| 1. PLACE OF DEATH- COUNTY Queen Anne MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Q.A. | |
| CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Kings Town | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Kings Town X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Chestertown (Rural) | | STREET ADDRESS (If rural, give location) 1 | |
| 3. NAME OF DECEASED (Type or Print) DOROTHY VICKERS ANTHONY | | 4. DATE OF DEATH March 5 / 55 19 | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH May 22, 1914 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 9. AGE last birthday 40 yrs. If under 1 year Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) Chestnut Hill, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Harrison W. Vickers Jr. | | 14. MOTHER'S MAIDEN NAME Rebecca B. Eliason | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) NO | | 16. SOCIAL SECURITY No. James T. Anthony III - Chestertown, Md. | |

18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

201X

Immediate cause (a) Hodgkin's disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

| | |
|---|---|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) |
| TIME (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work Not While At work |

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I hereby certify that I attended the deceased from 1948, 19, to 3-5, 1955, that I last saw the deceased alive on 3-5, 1955, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

| | | | |
|-------------------------|-------------------|--|---|
| SIGNATURE Robert W. Van | DATE Mar. 7, 1955 | NAME OF CEMETERY OR CREMATORY Chester Cemetery | LOCATION (City, town, or county) Chestertown, Md. |
|-------------------------|-------------------|--|---|

| | | | |
|--|-------------------|--|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Mar. 7, 1955 | NAME OF CEMETERY OR CREMATORY Chester Cemetery | LOCATION (City, town, or county) Chestertown, Md. |
|--|-------------------|--|---|

| | | | |
|------------------------------|-------------------------------------|--|---------|
| DATE REC'D BY LOCAL REG. 3-7 | REGISTRAR'S SIGNATURE Edgar L. Lane | 24. FUNERAL DIRECTOR Marvin V. Williams - Chestertown, Md. | ADDRESS |
|------------------------------|-------------------------------------|--|---------|

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 14 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3726

CERTIFICATE OF DEATH

Reg. Dist. No. 253 ...

| | | | | | | | |
|---|-------------------|--|---------------------|--|-----------------|--|-------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Queen Anne's</u> | | MARYLAND | | STATE <u>md</u> | | COUNTY <u>g. a.</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | | |
| X TOWN <u>near Chester</u> | | <u>Life</u> | | TOWN <u>Chester</u> <u>md</u> X | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 00 | | | | | | | |
| 3. NAME OF DECEASED: (Type or Print) | | | | 4. DATE (Month) (Day) (Year) OF DEATH: | | | |
| <u>Eliza</u> (First) <u>J</u> (Middle) <u>Reunn</u> (Last) | | | | <u>Mar 22</u> <u>1955</u> | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>Female</u> | <u>Col</u> | <u>Widow</u> | <u>April 1-1868</u> | <u>86</u> yrs. | Months | Days | Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| <u>Home Wife</u> | | | | <u>None</u> | | <u>md</u> | |
| 13. FATHER'S NAME: | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| <u>Perry Stansbury</u> | | | | <u>U.S.A.</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: | |
| <u>(If Yes, give war or dates of service)</u> | | | | <u>V</u> | | <u>Edward Johnson</u> <u>Stevensville</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 422.1 IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u> | | | | | | <u>One mo.</u> | |
| ANTECEDENT CAUSE (B) <u>Bronchial Pneumonia</u> | | | | | | <u>2 wks.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (C) <u>Arteriosclerosis</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| | | | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb.</u> , 19 <u>55</u> , to <u>Mar. 22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>55</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>B. Wm. Martin, Jr.</u> | | | | ADDRESS <u>Queenstown</u> | | DATE SIGNED <u>3/23/55</u> | |
| M. D. | | | | | | | |
| 23. BURIAL CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>Mar 26-55</u> | | <u>Bach Beach</u> | | <u>near Stevensville</u> <u>md</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>March 26, 55</u> | | <u>Elizabeth Kopter</u> | | <u>Edgar L. Lane</u> | | <u>Church Hill</u> <u>md</u> | |

BUREAU V. S.

MAR 31 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03011
3127 CERTIFICATE OF DEATH

Reg. Dist. No. 253

| | | | |
|--|--------------------------------|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Queen Anne</u> | MARYLAND | STATE <u>Ind.</u> | COUNTY <u>Queen Anne</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chester</u> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chester</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>08</u> | | STREET ADDRESS (If rural give location) <u>1</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | |
| <u>LEMUEL KIRWAN</u> | | OF DEATH: <u>Mar. 15</u> 19 <u>55</u> | |
| 5. SEX: <u>M</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>(Specify)</u> | 8. DATE OF BIRTH: <u>Feb. 29 - 1872</u> |
| 9. AGE last birthday <u>83</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired farm owner</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>James Kirwan</u> | | 14. MOTHER'S MAIDEN NAME: <u>Mary Gardner</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT & ADDRESS: <u>Katherine Kirwan - Chester Ind.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (A) <u>Coronary occlusion</u> | | | <u>March 15, 1955</u> |
| ANTECEDENT CAUSE (B) <u>mitral regurgitation + decompensation</u> | | | <u>2 years</u> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis general + cerebral</u> | | | <u>10 years</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chorea minor since childhood</u> | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 10, 1955</u> , to <u>March 15, 1955</u> , that I last saw the deceased alive on <u>March 14, 1955</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>Theodor Sattelmaier</u> | | ADDRESS <u>Stevensville</u> DATE SIGNED <u>March 16, 1955</u> | |
| 23. BURIAL CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | |
| <u>BURIAL</u> | | <u>Mar. 19</u> | |
| NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Kirwan</u> | | <u>near Chester Ind.</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | |
| <u>March 19, 1955</u> | | <u>Elizabeth Hooper</u> | |
| 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>Edgar L. Lane - Church Hill, Md.</u> | | | |

EXHIBIT A-2 OF DEATH

8323

BUREAU V. S.

MAR 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03012

328

CERTIFICATE OF DEATH

Reg. Dist. No. 253

| | | | | | | | |
|--|-----------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Queen Anne</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Queen Anne</u> | |
| CITY (If outside corporate limits, write RURAL OR TOWN) <u>X</u> <u>Stevensville</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stevensville</u> <u>X</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>no</u> | | | | STREET ADDRESS (If rural give location) <u>1</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>ETTA</u> <u>S.</u> <u>LONG</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>March 25</u> 19 <u>55</u> | | | |
| 5. SEX: <u>F.</u> | 6. COLOR OR RACE: <u>W.</u> | 7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: <u>April 7-1882</u> | 9. AGE last birthday <u>72</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME: <u>Wm. Gardner</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Virginia Harris</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | 16. SOCIAL SECURITY No. | | 17. INFORMANT & ADDRESS: <u>Miss Genevieve Long - Stevensville</u> | | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 292.4 IMMEDIATE CAUSE (A) <u>aplastic anemia</u> | | | | | | | <u>about 4 years</u> |
| ANTECEDENT CAUSE (B) <u>chronic septicemia</u> | | | | | | | <u>about 6 months</u> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Rheumatoid Arthritis</u> | | | | | | | <u>20 years</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: <u>/</u> | | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I hereby certify that I attended the deceased from <u>May 10</u> , 19 <u>50</u> , to <u>March 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 25</u> , 19 <u>55</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Theodor Sattelmair</u> | | | | ADDRESS <u>Stevensville</u> | | DATE SIGNED <u>March 26, 1955</u> | |
| 23. BURIAL CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF <u>Mar. 28</u> | | NAME OF CEMETERY OR CREMATORY <u>Stevensville</u> | | LOCATION (City, town, or county) (State) <u>Stevensville Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>March 28-55</u> | | REGISTRAR'S SIGNATURE <u>Elizabeth Koster</u> | | 24. FUNERAL DIRECTOR <u>Edgar L. Lane - Church Hill Md.</u> | | ADDRESS | |

RECEIVED

MAR 31 1965

BUREAU V. S.